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# THE VALUED VOICE

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## IN THIS ISSUE



## EDUCATIONAL EVENTS

**October 15, 2020**
*Telehealth Flexibilities: Reimbursement, Licensing and Credentialing*
Webinar

**October 20, 2020**
*Payment Past, Present and Future: A look into how commercial payments have evolved*
Webinar

**October 21, 2020**
*WHA Legislative and Regulatory Update: Impacts on Advanced Practice Nurse and Physician Assistant Care Delivery*
Webinar

## HHS Announces New $20 Billion CARES Act Distribution

On October 1, the U.S. Department of Health & Human Services (HHS) announced the newest round of funding from the federal CARES Act Provider Relief Fund (PRF).

In all, HHS announced $20 billion would be distributed to a variety of health care providers, including hospitals. All interested entities will need to apply for this funding, which HHS will distribute via the following methodology:

1. Any providers that have not yet received relief fund payments equal to at least 2 percent of patient care revenue will receive a payment that, when combined with prior payments (if any), equals 2 percent of patient care revenue;
2. Using any remaining balance of funds, if any, HHS will make "equitable" add-on payments with the following considerations: changes in operating revenues for patient care; providers' changes in operating expenses from patient care, including incurred expenses related to COVID-19; and payments already received through provider relief fund distributions.

While the application window is open through Nov. 6, HHS is encouraging applicants to apply early. To apply, go to this link and scroll down to "How to Apply for Phase 3 General Distribution."

Contact WHA Vice President of Federal and State Relations Jon Hoelter with questions.

## WHA & RWHC Object to Changes in Federal CARES Act Provider Relief Fund Guidance

In an October 6 letter to U.S. Department of Health and Human Services (HHS) Secretary Alex Azar, WHA partnered with the Rural Wisconsin Health Cooperative (RWHC) to express concerns over recent changes to the federal guidance governing how hospitals can use funding received from the Provider Relief Fund (PRF) authorized by the CARES Act. WHA also held a member webinar with corporate member Husch Blackwell covering this guidance. WHA members can view the webinar on WHA's on demand learning center.

At issue is guidance released on September 19 that significantly changed the definition of lost revenue. Prior to this change, the CARES Act and HHS guidance allowed a much broader definition of lost revenue, which essentially allowed hospitals to use the funding for any health care revenue lost due to coronavirus. WHA previously estimated Wisconsin hospitals and health systems lost around $2.5 billion statewide from the pause in elective procedures early in the pandemic and has estimated they have received about $1.1 billion in PRF funds. The change in guidance, however, redefined lost revenue to mean something closer to a change in a hospital's operating margin.

*(continued on page 2)*

*(WHA & RWHC Object to Changes in Federal CARES Act Provider Relief Fund Guidance . . . Continued from page 1)*

The change in guidance has created significant confusion and uncertainty over how hospitals will be able to spend COVID relief dollars. In the letter, WHA and RWHC noted that hospitals were led to understand both by a plain reading of the statute and initial guidance from HHS that lost revenue would be just that. However, as both noted in the letter, "All too often, our members make the best financial decisions they can with the information at hand only to have the rug swept out from under them as rules change midstream. This is unfortunately another example of that." The letter requests that HHS revert back to the former definition of lost revenue, which is more in line with the federal statute and Congress' original intent for these funds.

WHA has raised this issue with Wisconsin's Congressional Delegation and is continuing to ask for their support in ensuring HHS allows hospitals to use these funds in a way that is consistent with Congressional intent.

For more information, contact WHA Vice President of Federal and State Relations Jon Hoelter.

## WHA Comments on Proposed 340B and Site-Neutral Cuts, Changes to Hospital Quality Star Ratings in 2021 OPPS Rule

In its comment letter submitted to the Centers for Medicare and Medicaid Services (CMS) October 5, WHA expressed continued concerns about CMS' proposed cuts to 340B hospitals and hospital outpatient departments (HOPDs) in the proposed CY 2021 Hospital Outpatient Prospective Payment (OPPS) rule. Among other comments, WHA also noted both appreciation and caution over proposed changes to the CMS hospital quality star ratings.

In the proposed rule, CMS proposes either keeping the current policy of paying most 340B hospitals the Average Sales Price (ASP) minus 22.5% or imposing an even lower rate of ASP minus 28.7%. WHA noted that, for the proposed cut, CMS relied on a survey hospitals responded to in the midst of the pandemic, making the survey information inadequate and incomplete.

Given that the 340B program was designed to help hospitals "stretch scarce federal resources," and that the cuts are currently under appeal in the U.S. Court system, WHA urged CMS to abandon any level of cuts.

The proposed payment rule continues the policy of paying clinic visit services in grandfathered off-campus HOPDs at the physician fee schedule rate, which is 40% of the OPPS rate. Like the 340B program, WHA noted this issue is also under appeal in the courts and that hospitals should not have to shoulder these cuts during a pandemic that is severely stressing hospital resources. WHA also wrote that many of these HOPDs were previously physician clinic offices that were in jeopardy of closing due to poor patient mixes and low payment rates under the physician fee schedule. Forcing HOPDs to continue accepting these lower rates could jeopardize the ability to sustain access to care.

WHA also expressed both optimism and concern over proposals by CMS to overhaul the hospital quality star rating system. WHA has previously commented to CMS with concerns about the complexity of the star rating method, the unreliability of the results, and the inability of our members to use these ratings in a meaningful way. While it is encouraging that CMS has heard the feedback from WHA and others, WHA cautioned CMS against implementing these changes too quickly. WHA wrote that prior to refreshing proposed star ratings changes, CMS should ensure changes to methods have been finalized and a process is put in place to include an independent audit that ensures current and future changes are implemented correctly.

For more information, contact WHA Vice President of Federal and State Relations Jon Hoelter.

## WHA Urges CMS to Revise Proposed CY 2021 Physician Fee Schedule Rule

WHA submitted comments on the CY 2021 Medicare Physician Fee Schedule (PFS) proposed rule to the Centers for Medicare and Medicaid Services (CMS) on October 5. WHA expects a final rule in early December. A summary of WHA's comments follows:

**Conversion Factor.** In the rule, CMS proposed a decrease in Medicare physician payment rates of 10.61% in CY 2021. This proposed reduction would result in an estimated conversion factor of $32.26, a reduction of $3.83 from the CY 2020 conversion factor of $36.09. WHA strongly opposed this decrease. This significant reduction of the conversion factor could result in drastic cuts to many physician specialties. CMS proposed this conversion factor cut without any clear, transparent explanation into how it was calculated. Moreover, while these proposed changes may be budget neutral for Medicare as a whole, they would not be budget neutral for individual providers, including hospitals and health systems.

This change was made in conjunction with a revaluation of some Evaluation and Management (E/M) and related codes, which WHA urges CMS to finalize. Because of budget neutrality requirements, WHA urged CMS to work with Congress to secure a

*(continued on page 3)*

## Reminder – Community Benefits Stories Due Oct. 15!

WHA's annual Community Benefits report is an important way to highlight the crucial work hospitals do every day to support their communities. The report's collection of personalized stories about hospital and health system programs, including charity care, financial assistance and other hospital-supported initiatives, describes the positive impacts these programs have on patients, families and entire communities.

Go to https://www.surveymonkey.com/r/2020CBstories to submit your hospital's story with, whenever possible, a high-resolution image. In particular, please submit stories related to **COVID-19 Efforts, Charity Care, Free Clinics** and other **Hospital-Supported Initiatives**.

Contact WHA Communications Manager Shannon Nelson with any questions.

*(WHA Urges CMS to Revise Proposed CY 2021 Physician Fee Schedule Rule . . . continued from page 2)*

waiver of budget neutrality for the PFS for at least calendar years 2021 and 2022. Doing so would allow CMS to protect patient access to care by increasing payments for E/M visit codes without an overall cut to payments in excess of 10 percent.

If CMS cannot secure a waiver of budget neutrality from Congress, WHA asks CMS to delay the implementation of the revaluation of the E/M and related visit codes and the corresponding budget neutrality adjustment so as not to hinder the ongoing work hospitals and health systems must do in response to COVID-19.

### *Telehealth flexibilities*

Highlights of the rule's telehealth provisions include:

**New category for adding telehealth services.** In the rule, CMS proposes to create a new category for adding telehealth services to the Medicare telehealth list. In this new Category 3, services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic, and for which there is likely to be clinical benefit but there is not yet sufficient evidence available to consider the services as permanent additions, will remain on the list through the calendar year in which the PHE ends.

WHA asked CMS to provide additional direction regarding the type of evidence CMS is looking for in order for these codes to qualify for more permanent inclusion. WHA also asked CMS to consider keeping Category 3 services on the list for a longer period of time than a calendar year. This would allow more time to gather evidence which would support or refute the permanent addition of these services.

**Audio-only services.** WHA members have emphasized the importance of retaining reimbursement for audio-only telehealth services that was authorized during the PHE. These services have literally been a lifeline for patients without internet access, whether or not they live in rural areas. Senior citizens especially benefit from audio-only services as they may not have computers or if they do, may not feel comfortable using them for telehealth visits. Our members also report that behavioral health patients have embraced the opportunity to receive services over the telephone.

Because CMS does not believe it has authority, without Congressional action, to permanently add audio-only services to the Medicare telehealth list it is not proposing to continue to recognize audio-only payment codes under the PFS in the absence of the PHE for the COVID-19 pandemic. However, it acknowledges that the need for audio-only interactions could remain as beneficiaries continue to try to avoid sources of potential infection.

In its comment letter, WHA strongly urged CMS to move forward with coding and payment for a service similar to the virtual check-in, but for a longer unit of time and a higher value that would allow for use of telephone. Even when the PHE ends, it is likely that many patients will not feel comfortable leaving their homes until a vaccine is widely available, and in those cases, telephone may be the only way some patients have to access providers, and not all of them will have a pre-existing relationship.

**Remote Patient Monitoring (RPM)**. CMS proposes to continue reimbursement policies for RPM that it established during the PHE, but only for established patients. WHA disagrees with this limitation and urged CMS to retain RPM for new patients, as has been permitted under the PHE.

**Virtual supervision definition.** For the duration of the PHE for the COVID-19 pandemic, for purposes of limiting exposure to COVID-19, CMS adopted an interim final policy revising the definition of direct supervision to include virtual presence of the

*(continued on page 5)*

CELEBRATING 100 YEARS

# Improvement of Hospital Data; WHA Information Center Created

On October 31, 2003 then WHA President Steve Brenton and Department of Administration (DOA) Secretary Marc Marotta put pen to paper, signing the contract making transfer of hospital inpatient data collection from the Bureau of Health Information (BHI) to WHA official.

*From left: From the Department of Administration -- Sean Dilweg, Executive Assistant; James Johnston, Executive Policy and Budget Manager, and Marc Marotta, Secretary*
*From left: WHA -- Steve Brenton, Laura Leitch, and Eric Borgerding*

"It's a crucial time in the world of health care information," said Brenton, "a time in which WHA intends to lead, not follow."

As a result of this new partnership, Wisconsin hospitals were no longer assessed $1.3 million per year to fund the data collection efforts and the number of FTEs to run the program decreased from 25 to 4. The WHA Information Center (WHAIC) modernized the data collection process from an older bulletin-board type submission to a current web-based application that allows for real-time editing. This new system also enabled the collection of new categories of outpatient data and unlimited numbers of diagnoses, procedures and revenue-line detail, within seconds. The entire process from data submission to validation is paperless, and quicker, reducing data set turnaround time to 4 months down from 18 months from end of quarter.

Click to see *The Valued Voice* story from November 7, 2003.

Today, WHAIC's data capabilities continue to help the public and policymakers access accurate and useful information while empowering health care entities to continue improving care. In addition to collecting its own important data sets, WHAIC has become a valuable resource for aggregating data from other sources and turning it into meaningful information. WHAIC's COVID-19 Situational Awareness Update is a leading resource for information related to the COVID-19 pandemic, including dynamic display of important trends is just one example.

WHAIC is also well-positioned to be a key resource to inform how health care will look in the future. One key area of focus includes using data to identify health care disparities. Continuing to add valuable data is essential to better understand the current, and future, health care world. To that end, the WHAIC has become the only hospital association in the country to attain status as a Certified Quality Entity (QE) under the Centers for Medicare & Medicaid Services' Qualified Entity Certification Program. This will enable WHAIC to eventually receive Medicare Parts A and B medical claims data and Part D prescription drug claims data for use in evaluating provider performance and to help inform policy decisions.

See the WHA Information Center website.

# Register Today for WCMEW's Virtual Summit October Sessions

The Wisconsin Council on Medical Education and Workforce (WCMEW) is once again tackling the issue of Wisconsin health care workforce challenges with their annual education. This year, the education is coming to you by means of a virtual format with 1-2 sessions/month. Please review the brochure for session descriptions and registration information

*(WHA Urges CMS to Revise Proposed CY 2021 Physician Fee Schedule Rule . . . continued from page 3)*

supervising physician or practitioner using interactive audio/ video real-time communications technology. WHA supports continuing this policy beyond 2021, relying on the clinical expertise and discretion of as supervising physician or practitioner regarding the use of virtual supervision.

### *Quality Payment Program*

**Merit-Based Incentive Payment System (MIPS).** Under current MIPS policy, MIPS-eligible clinicians and groups participating in certain Alternative Payment Models (APMs) – including the Medicare Shared Savings Program (MSSP) – receive special scoring under the MIPS APM scoring standard. For CY 2021, CMS proposes to sunset the MIPS APM scoring standard, and replace it with a new APM performance pathway (APP) While the APP is similar to the APM scoring standard in several ways, it would significantly diverge from it by requiring clinicians and groups to report and be scored on a common set of six quality measures. These measures reflect diabetes control, depression screening/follow up, blood pressure control, patient experience, hospital-wide readmissions and admissions for multiple chronic conditions. This requirement would apply to APP participants regardless of the APM model in which they participate.

In its comment letter, WHA stated that requiring all MIPS APMs to report on the same six quality measures would be a misguided, "one size fits all" policy that fails to improve upon current policy, and urged CMS not to adopt it. WHA wrote that it is hard to understand how the six proposed measures could be equally relevant to all 12 of the APMs that currently meet MIPS APM requirements. For example, for clinicians participating in the Bundled Payment for Care Improvement Advanced (BPCI A) model, it is not clear how depression screening and follow up are relevant to those models that are focused on procedural inpatient care. Instead of adopting the APP model, we are asking CMS to instead to retain the existing requirement that MIPS APMs report the measures already required under their models.

**Removal of the Web Interface Reporting Option.** CMS proposes to abruptly end the use of the Web Interface reporting mechanism, a tool that has been used since the MSSP's inception. Removing this option for all ACOs with no notice is ill timed and unfair. WHA urged CMS to restore this reporting mechanism in the final rule.

If you have questions about the proposed rule and WHA's comments, please contact WHA's Laura Rose or Laura Leitch.

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## Optimize Your WHA Website Viewing

With the Internet Explorer (IE) browser no longer supported on Windows 7 operating systems, WHA's websites work best with Google Chrome or Microsoft Edge browsers. Using IE may result in errors on some parts of the website.